CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF EXAMINERS OF PSYCHOLOGISTS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS A PSYCHOLOGIST BY EXAMINATION
INSTRUCTION SHEET

When to File Application *by Examination*

Complete the *Application for Licensure as a Psychologist by Examination* if ***either*** of the following descriptions applies to you:

- You are not currently licensed in another state.

OR

- You are currently licensed in another jurisdiction and ***all*** of the following statements are true:
  - You have ***not*** practiced continuously for at least two years, *and*
  - You do ***not*** hold a Certificate of Professional Qualification in Psychology (CPQ), *and*
  - You are ***not*** credentialed by the National Registry of Health Service Providers in Psychology (NRHSPP).

If you don't meet the criteria above, complete the *Application for Licensure as a Psychologist by Reciprocity*.

Who Must Take the Examination

The exam for Delaware Psychologist licensure is the *Examination for Professional Practice in Psychology* (EPPP).

- If you have never passed the EPPP, the Board of Psychology must approve your application to take it.
- If you passed the EPPP over five years ago, you must re-take it. The Board must approve you to sit for the exam again.
- If you passed the EPPP less than five years ago, you do not need to re-take it.

If you need special accommodation due to a disability, complete and submit the *Request for Special Accommodation* form included with this application.

Requirements for *All* Applicants

☐ Submit completed, signed and notarized *Application for Licensure as a Psychologist by Examination* to the Board office.

☐ Enclose the non-refundable processing fee by check or money order made payable to "State of Delaware."
- If you hold an *active* Delaware Psychological Assistant Registration and are applying for upgrade to a Psychologist license, enclose the upgrade fee instead of the full processing fee.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.
- You must meet this requirement *even if* you recently had a criminal background check done for some other reason.

☐ Arrange for the Board office to receive an official transcript, sent directly from the college/university to the Board office, showing that you have a doctoral degree from a psychological studies program specifically designed to train and prepare psychologists.
- A doctoral degree from a program accredited by the American Psychological Association (APA) or the Psychological Clinical Science Accreditation System (PCSAS) meets this requirement.

☐ If your program is neither APA-accredited nor PCSAS-accredited, arrange for the Board office to receive the following to assist the Board in evaluating the program:

☐ Course descriptions (such as the course catalog)

☐ Completed *Evaluation of Coursework* form

This documentation is required *in addition to* the official transcript. It must show that your program meets the criteria in Sections 6.1.1.2.1 - 6.1.1.2.10.4 of the Board's Rules and Regulations.

☐ Arrange for your supervisor(s) to submit a *Supervisory Reference Form* directly the Board office.

- The forms must document that you have at least 1500 hours of post-doctoral supervised experience completed in not less than one calendar year and not more than three calendar years.

☐ If you have ever held a license in another jurisdiction (state, U.S. territory or District of Columbia), arrange for the Board office to receive verification of licensure from each jurisdiction where you have ever held a license, sent *directly* from the jurisdiction to the Board office.

☐ If you have passed the EPPP within the past five years, arrange for the Board office to receive a score report sent *directly* from the Association of State and Provincial Psychology Boards (ASPPB) to the Board office.

- To obtain a score report, see www.asppb.net.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2216) and for other lawful purposes.

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APPLICATION FOR LICENSURE AS A PSYCHOLOGIST BY EXAMINATION

TYPE OF APPLICATION

1. Select your licensure situation:

   ☐ I do not hold a *current* license in any other jurisdiction (state, U.S. territory or District of Columbia).

   ☐ I hold a *current* license in a jurisdiction other than Delaware ***but***
   - I do **no**t have two years of continuous experience after licensure.
   - I do **no**t hold a Certificate of Professional Qualification in Psychology (CPQ).
   - I am **not** credentialed by the National Registry of Health Service Providers in Psychology (NRHSPP).

2. Select the status of your *Examination for Professional Practice in Psychology* (EPPP):

   ☐ I have never passed the EPPP.

   ☐ I have taken and passed the EPPP within the past five years.

   ☐ I need to re-take the EPPP because I passed it over five years ago.

IDENTIFYING AND CONTACT INFORMATION

3. Name :_____ _____ _____
   Last/Family Name First Middle

4. Other Name(s) Used: None ☐ _____ _____ _____

5. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

6. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:**_____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

7. Mailing Address:_____

   _____ _____ _____
   City State Zip

8. Phone: _____ _____ Email: None ☐ _____
   Daytime Home

EDUCATION, EXAM AND INTERNSHIP

9. Enter your doctoral degree information below:

   University/College: _____ Major: _____

   City: _____ State: _____ Degree: _____

   Dates Attended: From: _____ To: _____ Graduation Date: _____
   month/day/year month/day/year month/day/year

   Arrange for the Board office to receive an official transcript, sent directly from the college/university to the Board office, showing that you have a doctoral degree from a psychological studies program specifically designed to train and prepare psychologists.

10. Was the doctoral program APA-accredited or PCSAS-accredited? Yes ☐ No ☐ **If no, submit a course catalog (or other course descriptions) and complete the *Evaluation of Coursework* form.**

11. Do you have a Diplomat of American Board of Examiners in Professional Psychology? Yes ☐ No ☐ **If yes, enter:**

    Diplomat Number: _____ Issue Date: _____ Specialty: _____

12. List your pre-doctoral internship experience. (Section 7.1 of the Board's Rules and Regulations explains this requirement.)

FACILITY NAME	CITY	STATE	DATES (month/day/year)		TOTAL WEEKS	TOTAL HOURS OF WORK EXPERIENCE
			From	To		

13. Have you passed the Examination for Professional Practice in Psychology (EPPP) during the past five years? Yes ☐ No ☐ **If yes, arrange for the Board office to receive a score report sent *directly* from the Association of State and Provincial Psychology Boards (ASPPB). Skip to the POST-DOCTORIAL PROFESSIONAL EXPERIENCE section.**

14. To take the examination, do you need special accommodation due to a disability? Yes ☐ No ☐ **If yes, complete the *Request for Special Accommodation* form.**

LICENSURE HISTORY

15. Are you (*or have you ever been*) licensed or certified as a psychologist in any other jurisdiction (state, U.S. territory or District of Columbia? Yes ☐ No ☐ **If yes, enter the following information about *each* license:**

JURISDICTION	LICENSE NUMBER	ISSUE DATE	STATUS (e.g., active)

Arrange for the Board office to receive verification of licensure from each jurisdiction where you have ever held a license, sent *directly* from the jurisdiction to the Board office.

Copy this page as needed.

POST-DOCTORAL PROFESSIONAL EXPERIENCE

16. Enter information about *each* location where you gained post-doctoral experience. Copy this page as needed.

Dates of Experience: From: ______/_______ To: ______/_______ Total Hours: ____________________________

Address: ____

Name of Supervisor (s): ____

Licensed Psychologist: Yes ☐ No ☐ License No: ____________________ Issue Date:__________________

Briefly describe your duties in this position. (Attach separate sheet if necessary):___________________________

____

____

____

Dates of Experience: From: ______/_______ To: ______/_______ Total Hours: ____________________________

Address: ____

Name of Supervisor (s): ____

Licensed Psychologist: Yes ☐ No ☐ License No: ____________________ Issue Date:__________________

Briefly describe your duties in this position. (Attach separate sheet if necessary):___________________________

____

____

____

Dates of Experience: From: ______/_______ To: ______/_______ Total Hours: ____________________________

Address: ____

Name of Supervisor (s): ____

Licensed Psychologist: Yes ☐ No ☐ License No: ____________________ Issue Date:__________________

Briefly describe your duties in this position. (Attach separate sheet if necessary):___________________________

____

____

____

Arrange for each supervisor to submit a *Supervisory Reference Form* directly to the Board office. The form(s) must show a total of at least 1500 hours of post-doctoral supervised experience over a one-year period but no more than three years.

DISCLOSURES

17. Have you ever had your professional license or registration subject to disciplinary action (including but not limited to consent agreements, fines, probation, suspension or revocation)? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include copies official Board orders or any other relevant documents.**

18. Are any disciplinary or ethical complaints currently pending against you in any other jurisdiction? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include any relevant documents.**

19. Has your application for a license or registration ever been refused or denied in any other jurisdiction? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include copies of all official documents or Board orders.**

20. Are you now, or have you *ever* been, dependent on the use of alcohol, stimulants, or habit-forming drugs? Yes ☐ No ☐ **If yes, submit a signed statement explaining fully. Include any relevant documents.**

Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the authorization form to arrange to be fingerprinted.

DUTY TO REPORT

21. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that ***any healthcare provider*** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Examiners of Psychologists
    - has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
    - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

    I certify that I have read and understand 24 *Del. C.* §3519, 24 *Del. C.* §1730, 24 *Del. C.* §1731 and 24 *Del. C.* §1731A and that I understand my *duty to report* to the Division of Professional Regulation. Yes ☐ No ☐

22. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C.* §903 and that I understand my *duty to report*. Yes ☐ No ☐

23. You have a ***mandatory*** duty to report to the Board of Examiners of Psychologists if you believe that a colleague has violated the APA's *Ethical Principles of Psychologists and Code of Conduct* (24 *Del. C.* §3514(a)(5)).

    I certify that I have read and understand Sections 1.04 and 1.05 of the APA Ethical Code, which explain when I am required report a colleague, and that I understand my *duty to report*. Yes ☐ No ☐

If Board review is required, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

Applications that are not complete within 12 months of filing may be considered abandoned and discarded. When your application is complete, allow 4-8 weeks to receive your license.

AFFIDAVIT

I hereby apply to be considered for licensing as a Psychologist by the Board of Examiners of Psychologists under the standards, qualifications and procedures established under Title 24, Chapter 35, of the *Delaware Code*. I have read the State statute governing psychologists in Delaware. I have also received and read the Board's Rules and Regulations regarding the practice of Psychology in Delaware. I understand that the Board may require evidence additional to the material herein, including a written examination, and transcripts of academic training.

I hereby swear or affirm that the information contained in this application is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

Signature: _____ Date: _____

County of_____State of _____

Sworn or affirmed before me a Notary Public this_____day of _____, 2_____.

Notary Signature: _____

SEAL

My commission expires on_____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR SUBMITTED WITHOUT THE REQUIRED FEE WILL BE REJECTED.

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EVALUATION OF COURSEWORK

Complete this form if your doctoral degree in psychology is from a program of studies that is ***not*** accredited by the American Psychological Association or the Psychological Clinical Science Accreditation System. The purpose of the form is to assist the Board in evaluating your coursework.

For each topic in the left column, enter the course number and title of the course(s) in the catalog that covered that topic.

History and Development	**Course #**	**Course Title**
Biological aspects of behavior		
Cognitive and affective aspects of behavior		
Social aspects of behavior		
History and systems of psychology		
Psychological measurement		
Research methodology		
Techniques of data analysis		

Foundations of Practice	**Course #**	**Course Title**
Individual differences in behavior		
Human development		
Dysfunctional behavior or psychopathology		
Professional Standards		
Ethics		

Diagnosing & Intervention Strategies	**Course #**	**Course Title**
Theories, methods of assessment & diagnosis		
Effective intervention		
Consultation and supervision		
Evaluating the efficacy of interventions		
Issues of cultural and individual diversity		

Submit a course catalog or course descriptions in addition to this form.

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SUPERVISORY REFERENCE FORM

INSTRUCTIONS

The purpose of this form is to verify the ***hours of post-doctoral experience*** that an applicant for Delaware Psychologist licensure has provided while under the ***supervision*** of an ***approved supervisor***. Please follow these instructions for completing this form.

- The supervisor must complete the entire form, sign it and mail it *directly* to the Board office at the address above.
- The applicant is ***not*** to complete any portion of the form. Forms not received *directly* from the supervisor will be rejected.
- An *approved supervisor* must be a licensed clinical psychologist, or licensed physician specializing in psychiatry.
- Applicants are required to have gained a total of at least 1500 hours of post-doctoral experience while under the direct supervision of one or more approved supervisors. When combined, the hours of supervision under all approved supervisors must span a period of *at least one year*. For more information about the supervision requirements, refer to Section 7.0 of the Board's Rules and Regulations available on http://dpr.delaware.gov/.

The information in this form may be released under the Delaware Freedom of Information Act. We encourage each supervisor to be candid and forthright in evaluating a candidate for licensure because the supervised professional experience must be completed in a manner satisfactory to the Board.

INFORMATION ABOUT APPLICANT

1. Applicant Name: _____ _____ _____
   Last First Middle

2. Mailing Address:_____

   _____ _____ _____
   City State Zip

INFORMATION ABOUT SUPERVISOR

3. Supervisor Name: _____ _____ _____
   Last First Middle

4. Supervisor's Title: _____ Degree:_____

5. License Number: _____ Date License Issued: _____

6. Practice Address: _____

   _____ _____ _____
   City State Zip

7. Phone: _____ _____ Email: None ☐ _____
   Daytime Home

VERIFICATION OF EXPERIENCE

8. During the period that you supervised the applicant, what was the applicant's professional identity?

   ☐ Psychologist ☐ Psychological Intern
   ☐ Registered/Certified Psychologist ☐ Trainee
   ☐ Registered Psychological Assistant ☐ Other: Specify: _____

9. Were you providing professional services at least 50% of the time in the same work setting where the applicant was gaining supervised professional experience? Yes ☐ No ☐

10. Describe *in detail* the training program and/or psychological duties the applicant performed under your supervision.

_____

_____

_____

_____

11. I would rate this applicant's performance while under my supervision as (check one):

☐ Acceptable ☐ Not Acceptable ☐ Unable to Evaluate

12. Provide the following information about the hours that the applicant worked under your supervision. Note that the hours you enter must be exact *numbers*.

LOCATION OF SUPERVISION	DATES (month/day/year)		TOTAL WEEKS WORKED	HOURS WORKED PER WEEK	TOTAL HOURS WORKED FOR ENTIRE PERIOD	HOURS OF DIRECT CLINICAL SERVICE PER WEEK	TOTAL HOURS OF DIRECT CLINICAL SERVICE FOR ENTIRE PERIOD
	From	To					

13. Provide a detailed breakdown of each type of supervision. *Note that the TOTAL must meet requirements of Section 7.2 of the Rules and Regulations:*

FORMAT OF SUPERVISION	HOURS PER WEEK
Individual Supervision:	
Group Supervision:	
Other Supervision – specify: _____	
TOTAL	

Include any other information you consider to be relevant on a separate page.

AFFIDAVIT

I hereby swear or affirm that the information contained in this form is correct and I understand that any intentionally fraudulent information will be reported to the Attorney General.

Supervisor Signature: _____ Date: _____

County of_____ State of _____

Sworn or affirmed before me a Notary Public this _____day of _____, 2_____

Notary Signature: _____

SEAL

My commission expires on: _____

Mail this form *directly* to the Board office at the address above.

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REQUEST FOR SPECIAL ACCOMMODATION

INSTRUCTIONS

Complete and submit this form to request one or more special accommodations due to a disability. To support your request, you must also submit a *current* (no more than three years old) and *comprehensive* report from a qualified examiner appropriate for evaluating your disability. The report must include the all of the following:

- Name, title, credentials and area of specialization of the qualified examiner
- Specific diagnosis
- Specific findings in support of the diagnosis (include relevant test results)
- Recommendation for specific accommodations
- Rationale for requesting specific accommodations

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last/Family First Middle
2. Other Name(s) Used: None ☐ _____ _____ _____
3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐
4. Mailing Address: _____
   _____ _____ _____
   City State Zip
5. Phone: _____ _____ Email: None ☐ _____
   daytime evening or cell

INFORMATION ABOUT YOUR DISABILITY AND REQUESTED ACCOMMODATIONS

6. What type of disability do you have? *State the specific diagnosis.* _____
   _____
   _____
7. When was your disability first diagnosed? _____
8. How does your disability affect your daily life? _____
   _____
   _____
   _____
   _____

9. How does your disability affect your ability to take computerized examinations? _____

_____

_____

_____

_____

10. What accommodations are you requesting? Refer to the ASPPB Accommodation Code Reference below for the definition of each item. *Check all that apply.*

☐ Adjustable Armless Chair	☐ Adjustable Contrast
☐ Adjustable Font Size	☐ Adjustable Work Station
☐ ASL Interpreter Directions	☐ Bag Lunch/Snack/Beverage
☐ Blood Sugar	☐ Candy/Snacks
☐ Ergonomic Chair	☐ Ergonomic Keyboard
☐ Extra Time – 1 Hour	☐ Separate Room
☐ Extra Time – Time and 1/2	☐ Separate Room and Lip Speaker
☐ Extra Time – 30 Minutes	☐ Separate Room and Reader/Recorder
☐ Extra Time – Double Time	☐ Separate Room and Reader
☐ Frequent/Extended Breaks	☐ Separate Room and Recorder
☐ Glucose Meter	☐ Separate Room and Service Animal
☐ JAWS (TTS)	☐ Separate Room and Sign Language Interpreter
☐ Medicine	☐ Trackball Mouse
☐ Oxygen	☐ ZoomText (Screen Mag Only)
☐ Water Bottle	☐ Other:_____

Attach a copy of your current evaluation report (*no more than three years old*)

11. Have you received accommodations for the EPPP examination before? Yes ☐ No ☐ If yes, explain what accommodations you received:_____

_____

_____

_____

CANDIDATE AFFIRMATION

I affirm that the information I have provided on this request is true and accurate. I have truthfully represented my disability and the impact it has on my daily life and computerized examinations.

Signature of Applicant: _____ Date: _____

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county***. As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

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AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians, Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name | First Name | Middle Initial | Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____

Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

Revised 8/2017